PRINTED: 06/24/2009 FORM APPROVED Bureau of Health Care Quality & Compliance STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING **NVN312AGC** 12/16/2008 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2907 N MOUNTAIN STREET **MOUNTAIN SPRINGS ASSISTED COMM CARSON CITY, NV 89703** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE **PREFIX PREFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) Y 000 **Initial Comments** Y 000 The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. This Statement of Deficiencies was generated as a result of an annual State Licensure survey conducted in your facility on 12/16/08. This State Licensure survey was conducted by the authority of NRS 449.150, Powers of the Health Division. The facility is licensed for 60 Residential Facility for Group beds for elderly disabled persons, Category II. The census at the time of the survey was 57 residents. Fifty-seven resident Medication Administration Records were reviewed. Twenty-four resident files were reviewed and ten employee files were reviewed. One discharged resident file was reviewed.

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE

(X6) DATE

This Regulation is not met as evidenced by: Based on record review on 12/16/08, the facility

The following deficiencies were identified:

449.200(1)(d) Personnel File - NAC 441A

1. Except as otherwise provided in subsection 2, a separate personnel file must be kept for each member of the staff of a facility and must include: (d) The health certificates required pursuant to chapter 441A of NAC for the employee.

Y 103

NAC 449,200

SS=E

Y 103

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		(X1) PROVIDER/SUPPLIER/ IDENTIFICATION NUME		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED			
NVN312AGC			B. WING			12/16/2008			
NAME OF PROVIDER OR SUPPLIER MOUNTAIN SPRINGS ASSISTED COMM			STREET ADDRESS, CITY, STATE, ZIP CODE 2907 N MOUNTAIN STREET CARSON CITY, NV 89703						
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Y 103	Continued From page 1 failed to ensure that 3 of 10 employees complied with NAC 441A.375 regarding tuberculosis testing (Employee #1, #3 and #6). This was a repeat deficiency from the State Licensure survey dated 12/4/07. Severity: 2 Scope: 2 449.200(1)(f) Personnel File - Background Check			Y 103					
SS=D	NAC 449.200 1. Except as otherwise a separate personner member of the staff of	se provided in subsectivel file must be kept for each of a facility and must inclinance with NRS 449.17	on 2, ach clude:	1 103					
	Based on record revi failed to ensure 2 of	equirements (Employee	cility						
Y 250 SS=F	449.217(1) Kitchens-Equipment works; Clean and Sanitary			Y 250					
	facility and the size of adequate for the nun facility. The kitchen clean and must allow	a kitchen of a residention of the kitchen must be an arrow of residents in the and the equipment must for the sanitary preparted must be in good wo	st be ration						

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This Regulation is not met as evidenced by: Based on observation on 12/16/08, the facility did not ensure cleaning compounds were not stored

in any area in which food was stored.

Severity: 2 Scope: 3

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED			
NVN312AGC		NVN312AGC		B. WING		12/16/2008			
NAME OF PR	OVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	ATE, ZIP CODE				
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Y 256	Continued From page		Y 256						
Y 256 SS=C	449.217(6)(b) Permits - Have necessary permits			Y 256					
	• •	y with more than 10 sary permits from the B Services of the Division							
	This Regulation is not Based on record revior 12/16/08, the facility of from the Bureau of Honor 1 of 2 kitchens.	permit							
	Severity: 1 Scope: 3								
Y 878 SS=D	449.2742(6)(a)(1) Medication / Change order			Y 878					
	the physician. If a ph the amount or times r administered to a res	tion prescribed by a ministered as prescribe sysician orders a chang medication is to be ident: ponsible for assisting ir medication shall:	e in						

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FORM APPROVED Bureau of Health Care Quality & Compliance STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING NVN312AGC 12/16/2008 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2907 N MOUNTAIN STREET **MOUNTAIN SPRINGS ASSISTED COMM CARSON CITY, NV 89703** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFIX **PREFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) DATE CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) Y 878 Continued From page 4 Y 878 This Regulation is not met as evidenced by: Based on record review and interview on 12/16/08, the facility failed to ensure medications were available in the facility to administer as prescribed to 13 of 57 residents (Resident #1, #2, #5, #6, #8, #11, #14, #17, #19, #21, #22, #23 and #24). Severity: 2 Scope: 1